

**N311 Care Plan 1**

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Lakeview College of Nursing

N311: Foundations of Professional Practice

Professor Henry

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### Demographics (5 points)

|  |                                 |                                   |   |
|--|---------------------------------|-----------------------------------|---|
| <b>Date of Admission</b><br>9/22/2024                    | <b>Client Initials</b><br>JMZ   | <b>Age</b><br>60 y.o              | <b>Gender</b><br>Female                               |
| <b>Race/Ethnicity</b><br>White/Caucasian<br>Non-Hispanic | <b>Occupation</b><br>Unemployed | <b>Marital Status</b><br>Divorced | <b>Allergies</b><br>Codeine – Rash<br>Morphine – Rash |
| <b>Code Status</b><br>Full (No ACP Docs)                 | <b>Height</b><br>4’11”          | <b>Weight</b><br>181 lbs 14.1 oz  |   |

### Medical History (5 Points)

**Past Medical History:** Arthritis, Carcinoma in situ of liver and/or biliary system, Diabetes mellitus, Hyperlipidemia

**Past Surgical History:** Cesarean section, Tubal ligation, Central venous catheter (left)

**Family History:** Son (Deceased) – Muscular Dystrophy, patient denies any maternal or paternal health history.

**Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use):**

Patient denies smoking, use of tobacco products, or recreational drugs. She is not currently using alcohol.

### Admission Assessment

**Chief Complaint (2 points):** Bloody nose and Generalized Weakness

**History of Present Illness – OLD CARTS (10 points):**

On arrival to the Emergency Department, patient stated her nose bleed had been ongoing for over a week. The generalized weakness had been ongoing and had progressed over the last two weeks. The patient’s nose was not bleeding upon arrival. Patient states that she experiences bleeding from the nose off and on. The patient describes the generalized weakness as a feeling of confusion and consistent fatigue. The patient was started on FOLFOX regimen on 8/20/2024

prior to the arrival of symptoms. Patient denies any relieving factors. The epistaxis and generalized weakness interfered with patients daily living.

### **Primary Diagnosis**

**Primary Diagnosis on Admission (3 points): Thrombocytopenia**

**Secondary Diagnosis (if applicable): Cholangiocarcinoma (Stage 4)**

### **Pathophysiology**

**Pathophysiology of the Disease, APA format (20 points):**

#### **Disease Pathophysiology**

Thrombocytopenia is categorized by an abnormally low platelet count in the blood. Platelets, also known as thrombocytes, are cell fragments within the body that are necessary to prevent and stop bleeding through the formation of clots. Platelet counts of less than  $150 \times 10^3 \mu\text{L}$  are generally diagnosed as Thrombocytopenia (Weycker et al., 2020). Low platelet levels are usually caused by the body's inability to produce new platelets or accelerated platelet destruction (Liu et al., 2023). Low levels of blood platelets pose an increased risk of uncontrolled external or internal bleeding. The individual is also at a high risk for potentially fatal bleeding into the brain. Mild thrombocytopenia is not considered emergent but severe thrombocytopenia can be fatal (Mayo, 2022).

#### **Etiology**

Thrombocytopenia can have several differing causations affecting both adults and children. The most common form is immune thrombocytopenia which is associated with the body's immune system attacking and depleting the platelets in the blood. This can be caused by acute or chronic infection, blood cancers, pregnancy, or immune disorders such as lupus (Weycker et al., 2020). Other external causes of low platelet counts are certain medications or

certain vaccinations. Thrombocytopenia may also occur as the result of a bone marrow disorder. Thrombocytopenia can be classified as acute or chronic depending on the cause (Mayo, 2022).

### **Signs and Symptoms**

Thrombocytopenia can present through several signs and symptoms. These may include easy or excessive bruising and bleeding, petechiae, epistaxis, bleeding from the gums, blood in the urine or stool, fatigue, or an enlarged spleen (Mayo, 2022). Patients' symptoms may differ depending on the severity of the disease. Some may experience no signs at all.

### **Diagnostic Testing**

Thrombocytopenia can be diagnosed through a multitude of diagnostic tests. These include blood tests, bone marrow tests, imaging, and physical assessments (Liu et al., 2023). A complete blood count is the most common diagnostic test used and is the most accurate (Mayo, 2022). A complete blood count supplies the blood platelet level which can be determined as high, low, or normal. Bone marrow testing usually consists of a marrow biopsy. The sample of bone marrow can be assessed to determine if the body is producing platelets efficiently (Shrestha, 2020). Imaging can be used primarily to identify an enlarged spleen. However, an enlarged spleen does not always present in thrombocytopenia cases. A physical assessment allows for a healthcare professional to identify potential bruising and palpate for an enlarged spleen in the abdomen (Mayo, 2022). These symptoms do not always present in all cases.

### **Treatment**

Treatment for thrombocytopenia is dependent on the causation and severity of the disease. Potential treatments may consist of medication, blood transfusions, or splenectomy (Liu et al., 2023). Certain acute cases may not need medically treated and will resolve on their own.

## References

- Liu, Xg., Hou, Y. & Hou, M. (2023). How we treat primary immune thrombocytopenia in adults. *J Hematol Oncol* **16**, 4. <https://doi.org/10.1186/s13045-023-01401-z>
- Mayo Foundation for Medical Education and Research. (2022). *Thrombocytopenia (low platelet count)*. Mayo Clinic.  
<https://www.mayoclinic.org/diseases-conditions/thrombocytopenia/symptoms-causes/syc-20378293>
- Shrestha, S., Nazy, I., Smith, J. W., Kelton, J. G., Arnold, D. M. (2020). Platelet autoantibodies in the bone marrow of patients with immune thrombocytopenia. *Blood Adv* 4 (13): 2962–2966. doi: <https://doi.org/10.1182/bloodadvances.2020001846>
- Weycker D, Hanau A, Hatfield M, Wu H, Sharma A, Bensink ME, et al. (2020). Primary immune thrombocytopenia in US clinical practice: incidence and healthcare burden in first 12 months following diagnosis. *J Med Econ.* 23(2):184–92.

**Pathophysiology References (2) (APA):****Vital Signs, 1 set (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS**

| <b>Time</b> | <b>Pulse</b>  | <b>B/P</b>    | <b>Resp Rate</b> | <b>Temp</b>   | <b>Oxygen</b> |
|-------------|---------------|---------------|------------------|---------------|---------------|
| <b>1449</b> | <b>87 bpm</b> | <b>103/61</b> | <b>19</b>        | <b>97.8 F</b> | <b>99%</b>    |

**Pain Assessment, 1 set (5 points)**

| <b>Time</b> | <b>Scale</b> | <b>Location</b> | <b>Severity</b> | <b>Characteristics</b>            | <b>Interventions</b> |
|-------------|--------------|-----------------|-----------------|-----------------------------------|----------------------|
| <b>1449</b> | <b>NRS</b>   |                 | <b>0</b>        | <b>No pain during assessment.</b> |                      |